DEPARTMENT OF HEALTH & HUMAN SERVICES Health Care Financing Administration

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

QIP TOPS CONTROL NUMBER: PRO 2000-21

DATE: August 23, 2000

FROM: Technical Advisor
Division of Contract Performance and Policy
Quality Improvement Group
Office of Clinical Standards and Quality

SUBJECT: PRO Review Related to the Medicare Outpatient Prospective Payment System (OPPS)

TO: Associate Regional Administrators, DCSQ
Regions I, VI, VII, IX
Chief Executive Officers, All PROs

New Policy

PROs must adhere to the new national Medicare policy with regard to the classification of "inpatient only" procedures listed in Addendum E of the OPPS final rule dated April 7, 2000. Furthermore, PROs need to be aware that 16 procedures codes were removed from this inpatient list, and instructions have been issued to intermediaries and carriers on how to process these claims (see attached program memorandum). The national Medicare policy is effective for services furnished on or after August 1, 2000.

PROs are to revise their medical review criteria, as appropriate, to reflect that these procedures are performed in a hospital inpatient setting (beginning August 1, 2000). Like other inpatient hospital services, PROs are to deny these inpatient services when they are found to be not medically necessary or appropriate. However, if these services are medically necessary, they must be allowed in the inpatient setting.

Background

The hospital OPPS applies to any hospital participating in the Medicare program except (1) those services furnished by Maryland hospitals that are paid under a cost containment waiver (section 1814(b)(3) of the Social Security Act (the Act) and (2) critical access hospitals. The regulation at 42 C.F.R. 419.21 specifies the hospital outpatient services subject to OPPS. The services and procedures that the secretary designates, as requiring inpatient care is one of the types of services that are not paid under the hospital OPPS. Inpatient procedures are those that, in the judgment of HCFA's medical advisors and staff, would not be safe, appropriate, or considered to fall within the boundaries of acceptable medical practice if they were performed on other than a hospital inpatient setting.

The “inpatient only” procedures listed in Addendum E of the OPPS final rule (dated April 7, 2000) represents national Medicare policy. The preamble of this regulation specifies that this national policy is binding on intermediaries and PROs as well as on hospitals and Medicare participating ambulatory surgical centers. The procedures on the inpatient list are considered to be a program benefit only when they are billed as inpatient procedures (and can be denied when found to be not medically necessary/appropriate services). Subsequently, if the service is performed on an outpatient basis and a claim is submitted, the claim will be denied, and the beneficiary may be billed for the service.

Services included in the OPPS and assigned to an ambulatory payment classification (APC) group may be performed on an inpatient basis when the patient’s condition warrants inpatient admission. One of the primary factors considered as an indicator for the “inpatient only” designation is the need for at least 24 hours of postoperative care. Routinely billing an observation stay for patients recovering from outpatient surgery was not allowed under the previous Medicare rules nor it is allowed under the new hospital OPPS. In November 1996, HCFA issued instructions limiting covered observation services to no more than 48 hours except in the most extreme circumstances. The ambulatory payment classification (APC) payment for emergency room visits includes the costs of observation within the payment.

As part of HCFA’s annual update process, procedures on the “inpatient only” list will be reevaluated. As medical practice changes, HCFA will move procedures to the outpatient setting in accordance with section 1833(t)(6)(A) of the Social Security Act. Your comments on services that do not belong on the “inpatient only list” are welcome at any time; however, revisions to the list occur only in January of each year. These comments can be sent to Kitty Ahern at kahern@hcfa.gov.

For further questions or clarification, you may contact me at (410) 786-6871 or Ajackson1 @hcfa.gov.

/s/
Amelia R. Jackson, B.S.N., M.S.

PRO Manual Section: None
PRO SOW Section: None
RO Control Number: None

Attachment

DATE: **August 1, 2000**

ELECTRONIC MAIL NOTE NO. **RO-1106**

NOTE TO: ALL REGIONS

SUBJECT: Advance Copy of Program Instructions Available for Retrieval--INFORMATION

The following Word 97 files are now available for retrieval:

PUB. NO./NAME		REV. NO	RETRIEVAL TITLE
60A	Program Memorandum Intermediaries **Change Request 1296**	A-00-45	A-00-45.doc
60AB	Program Memorandum Intermediaries/Carriers **Change Request 1039**	AB-00-69	AB00-69.doc

The transmittal page(s) of the above issuances is attached for your review.

We suggest that you keep a printed copy of this note and accompanying transmittal pages for a period of 1 month. This will give you a reference source of retrieval titles and the subject matter of issuances that have been sent to your mailbox.

PLEASE RETRIEVE OR DELETE THE ABOVE ISSUANCES IMMEDIATELY.

If you have any questions, please call **Bridget D. Wilhite at (410) 786-5248.**

/s/
Seth A. Price III
Director of Issuances Branch
Division of Regulations & Issuances
Offices of Communications & Operations Support

Attachments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Refer to: MCMG-DCM

DATE: August 1, 2000

FROM: Deputy Director
for Medicare Contractor Management, CBS

SUBJECT: Medicare Contractor Implementing Instruction Approved Through the HCFA Change Management Process--ACTION

TO: Medicare Fiscal Intermediaries and/or Carriers

Attached is a HCFA instruction which should be implemented by all Medicare Fiscal Intermediaries and/or Carriers. The changes required as a result of this instruction have been evaluated and approved through the HCFA Change Management Process. Please proceed in taking necessary action to implement this by the date indicated.

Any questions should be directed to your HCFA Regional Office.

/s/
Marjorie Kanof, M. D.

Attachments
Change Request 1039
Change Request 1296

cc:
Regional Offices

Program Memorandum Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal A-00-45 **Date: AUGUST 1, 2000**

CHANGE REQUEST 1296

SUBJECT: Interim Process for Certain "Inpatient Only" Code Changes

As discussed in the outpatient prospective payment system (OPPS) final rule, which was published in the ***Federal Register*** on April 7, 2000, there are certain procedures that will not be paid if performed on an outpatient basis. A hospital will receive Medicare payment for these procedures only when they are furnished to their inpatients. The HCPCS codes that are on the "inpatient only" list were published in Addendum E of the final rule. However, certain codes from the list were erroneously included as inpatient only procedures and as a result will be removed from the list.

The following is a list of HCPCS codes which will be removed from the inpatient only list. These codes will be assigned and paid under the APCs indicated.

HCPCS Code	Description	APC
74300	X-ray bile ducts/pancreas	0263
75945	Intravascular us	0267
75946	Intravascular us add on	0267
75960	Transcatheter intro, stent	0279
75961	Retrieval, broken catheter	0279
75962	Repair arterial blockage	0280
75964	Repair artery blockage, each	0279
75966	Repair arterial blockage	0280
75968	Repair artery blockage, each	0279
75970	Vascular biopsy	0279
75978	Repair venous blockage	0279
75992	Atherectomy	0279
75995	Atherectomy	0279
92977	Dissolve clot, heart vessel	0120
95920	Intraop nerve test add on	0216
95961	Electrode stimulation, brain	0216
95962	Electrode stim, brain add on	0216

Program Memorandum
Intermediaries/Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-00-69 **Date: AUGUST 1, 2000**

CHANGE REQUEST 1039

SUBJECT: Notice of New Interest Rate for Medicare Overpayments and Underpayments

Medicare Regulation 42 CFR §405.378 provides for the assessment of interest at the higher of the private consumer rate (PCR) or the current value of funds (CVF) rate (5 percent) for calendar year 2000. The Secretary of the Treasury has notified the Department of Health and Human Services that the PCR has been revised to 13.875 percent. The new PCR was published in the ***Federal Register*** (see Vol. 65, No. 148 dated 08/01/2000).

Therefore, the new revised PCR is effective August 1, 2000, the date it was published in the *Federal Register*. It will remain in effect until a new rate change is published. Please make system changes as needed to insure the new interest rate is implemented timely. In addition this reaffirms interest rates for prior periods.

INTEREST RATE TABLE

Period	Interest Rate
October 24, 1996 - January 22, 1997	13.375%
January 23, 1997 - April 23, 1997	13.625%
April 24, 1997 - July 24, 1997	13.50%
July 25, 1997 - October 23, 1997	13.75%
October 24, 1997 - January 27, 1998	13.875%
January 28, 1998 - May 12, 1998	14.50%
May 13, 1998 - July 30. 1998	14.00 %
July 31, 1998 - October 22, 1998	13.75%
October 23, 1998 - January 31, 1999	13.50%
February 01, 1999 - May 04. 1999	13.75%
May 05, 1999 - August 03, 1999	13.375%
August 04, 1999 - October 27,1999	13.25%
October 28, 1999 - February 1, 2000	13.375%
February 2, 2000 - May 2, 2000	13.5%
May 3, 2000 - July 31, 2000	13.75%
August 1, 2000	**13.875%**

These instructions should be implemented within your current operating budget.

The *effective date* for this Program Memorandum (PM) is August 1, 2000.

The *implementation date* for this PM is August 1, 2000.

This PM may be discarded October 31, 2000.

Contact person for this PM is Tom Noplock on (410) 786-3378.